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FOR ACTION

COUNTRY PROGRAMME RECOMMENDATION*

United Republic of Tanzania

The Executive Director recommends that the Executive Board approve the country programme of the United Republic of Tanzania for the period 1992-1996 in the amount of $38,500,000 from general resources, subject to the availability of funds, and $29,851,000 in supplementary funds, subject to the availability of specific-purpose contributions.

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* In order to meet documentation deadlines, the present document was prepared before aggregate financial data were finalized. Final adjustments, taking into account unspent balances of programme cooperation at the end of 1991, will be contained in the "Summary of 1992 recommendations for general resources and supplementary funding programmes" (E/ICEF/1992/P/L.2 and Add.1).

THE SITUATION OF CHILDREN AND WOMEN

1. Every year in the United Republic of Tanzania, 231,000 children die before they reach five years of age. The widespread combination of malnutrition and disease causes the deaths of 112 out of every 1,000 children before their first birthday. Between 40 and 60 per cent of the country's 4.5 million children under five years of age are malnourished; between 4 and 9 per cent are severely malnourished and eight times more likely to die than better nourished children. Tanzanian women face a risk of death in childbirth that is 50 times greater than that of women in northern Europe. Their babies, if born alive, are 10 times more likely to die in the first year than those in northern Europe. The maternal mortality rate (MMR) is 340 per 100,000 live births.

2. Women and children in rural areas, especially those in the peripheral southern and western regions, are at even greater risk than those in urban areas.

3. In addition to high-risk pregnancies, women's health is also undermined by heavy workloads, short birth intervals, inadequate food intake, recurrent malaria and anaemia. Because the referral system often cannot cope with emergencies that arise during childbirth, haemorrhage, sepsis and obstructed labour are immediate causes of maternal death.

4. More than half of infant deaths occur in the first month after birth, and most of those in the first week. Perinatal deaths are estimated at 70 per 1,000 births and the risk is even greater for the 14 per cent born with low birth weight.

5. For children who survive, the opportunities for good health are undermined in infancy - or earlier in the womb of a malnourished mother - by wasting and stunting resulting from malnutrition. Growth retardation usually starts at the fourth or sixth month of life, when exclusive, on-demand breast-feeding no longer meets energy needs, low-energy, bulky weaning foods are introduced and feeding frequency is reduced to the inadequate adult rate of only two or three times per day.

6. Malnourished children are at a disadvantage in the struggle against malaria, the single most dangerous disease in the United Republic of Tanzania. Malnutrition, together with malaria, dehydration caused by diarrhoeal diseases and respiratory infections, cause 80 per cent of the deaths of children under five years of age. Immunization rates of 80 per cent have substantially reduced the toll of measles, tetanus and other vaccine-preventable diseases. Unfortunately, while there has been a decline in measles cases in children, there has also been a serious rise in the incidence of malaria.

7. The mortality reductions once expected from high immunization rates are likely to be affected by acquired immune deficiency syndrome (AIDS), which is beginning to have a major impact nine years after it was first reported in 1983. Preventive measures are starting to have some effect, but with an estimated 500,000 adult women (7 per cent) already infected in 1990, each with a 30 per cent chance of infecting an unborn child in the event of a pregnancy, the risk of death to infants and children is increasing.

8. Care and support for women and children is inadequate, both inside and outside the home. Women are responsible for the home, and unhelped by technology, spend much time and energy on laborious food production and processing, on carrying water and fuel and on some supplementary income generation, usually spending long hours in small enterprises with low returns. They never get time, even during pregnancy, for the rest essential to their own health.

9. Child care depends on the available time of parents, especially mothers, whose relentless domestic work burden deprives them of the time and income needed to provide proper care. In addition to the impact on early childhood development and education, a lack of care also restricts children's feeding frequency and food intake, thus inducing the onset of malnutrition.

10. The social service infrastructure is well established, with a primary school in every village, health services within five kilometres of 70 per cent of the rural population and improved water supplies available to half of those people. However, chronic underfunding and deteriorating conditions of employment for staff have affected the quality of all services, reducing service utilization. The enrolment of both girls and boys in primary education is close to 80 per cent and literacy rates among women and men are close to 90 per cent. People participate in water supply and sanitation programmes, almost all women attend an antenatal clinic at least once during pregnancy and children are brought in for vaccination.

11. Legally, women enjoy equal rights, but legislation also recognizes customary laws that debar them from land ownership and child custody. Women's participation in decision-making bodies is limited at all levels; by 1990, no more than 10 per cent of the members of Parliament and village government committees were women. Such restrictions prevent women from controlling the resources necessary for child survival and development (CSD). Paradoxically, many of the actions to improve the situation of children and women are expected to be taken by women, but men control the resources.

12. The United Republic of Tanzania's per capita income, estimated by the World Bank to be $130 per person in 1989, is among the lowest in the world. The Government has worked to accommodate affirmative strategies that put people at the centre of development, but in real terms, allocations for social programmes have fallen because of the general economic decline. Social expenditures have been further constrained by debt servicing, high overhead

costs and the loss of crop marketing institutions. In recent years, between one fourth and one third of the government budget has been used to service debt. Economic recovery strategies, susceptible to reversal by developments beyond government control and heavily dependent on aid, emphasize the generation of export income and the reduction of the central economic administration, as well as encourage more community responsibility for social services. Those who will benefit most in the short term are those with relative economic or management strength, and not the poorest areas of the country and the most vulnerable households.

PROGRAMME COOPERATION, 1987-1991

13. Aimed at accelerating the reduction of infant and young child mortality rates, the programme directed 66 per cent of its support to national sectoral programmes administered by central ministries and 34 per cent to regions and districts for the implementation of integrated community-based programmes. (Because of the large value of the essential drugs programme, it has been excluded from these data.) Programme impact was particularly significant in the community-based programmes, with severe malnutrition rates reduced by half in less than three years and substantial reductions achieved in total malnutrition.

14. Strongly influenced by the experience and achievements of the Iringa Joint Nutrition Support Programme (JNSP), the conclusions of the 1986 mid-term review and the 1988 evaluation, the country programme strategy recognized both the needs and opportunities for addressing the immediate, underlying and basic causes of child deaths. It particularly emphasized the local generation and use of information as an essential tool for understanding the causes of problems and for planning actions to solve them. The strategic introduction of information systems, focused on children's nutritional status, was an effective entry point for the development of programmes that have tackled not only the poor condition of children, but also the sensitive issues of women's poor status.

15. At Iringa, the rate of severe malhutrition was reduced by more than 50 per cent in two years; similar substantial reductions were achieved in other regions. Implementation of community-based programmes has emphasized the most cost-effective aspects (communication, monitoring, training and direct intervention for the most pressing problems of children) identified through analyses of data on the nutritional status of children from the monitoring system and on the costs of various elements of the programme.

16. Between 1987 and 1991, UNICEF support in nine regions to nutrition and household food security, water supply, environmental sanitation and hygiene, women's economic activities, child development and programme communication was integrated with CSD activities, using the community-based, growth monitoring system as a management and information system.

17. UNICEF support in the remaining 11 regions of the mainland was mostly through national programmes such as immunization, essential drugs, maternal and child health (MCH) services and Facts for Life. Those national programmes were also a major feature of UNICEF support in Zanzibar. This support, provided separately through the Revolutionary Government of Zanzibar, was expanded significantly with the introduction of the Zanzibar JNSP in 1989.

18. Within the programme strategy, consistent efforts were made to redirect the national programmes to be fully integrated into and supportive of the district and community-based approach, implying responsiveness to community-based processes rather than vertical approaches. The reorientation, given additional momentum by the mid-term review, has taken longer in some programmes than others.

19. Support for improvements in the health of women and children covered a wide range of actions, with notable achievements. With support from UNICEF, the Danish International Development Agency (DANIDA) and the World Health Organization (WHO), the United Republic of Tanzania in 1988 became the first major country in sub-Saharan Africa to achieve universal child immunization. This left it free to aim at consolidation, sustainability and improved disease monitoring for impact assessment during the 1990s and better placed to achieve the global targets for measles control, neonatal tetanus and poliomyelitis eradication. A recently completed cost-reduction study for the immunization programme, supported by UNICEF, has shown that $1 million in vaccine costs alone might be saved annually by adopting a strategy of specific vaccination days in health facilities rather than providing vaccination on demand.

20. The essential drugs programme was the major consistent, reliable source of drugs for rural health facilities in the mainland and on Zanzibar. UNICEF procured the drugs and facilitated their delivery in kits to every district in the country. Beginning in 1990, the kit composition was changed to be more responsive to the needs of pregnant women, including supplementary items for malaria and anaemia. A comprehensive review of national drugs requirements was concluded in September 1991, with the participation of UNICEF staff. That review will provide the basis for future external support.

21. UNICEF and the United Nations Population Fund (UNFPA), concerned about the relative neglect of the major health problems of women, helped to launch the safe motherhood initiative on the mainland in 1989, with the aim of raising the status of women and improving family planning, family life education, maternal health services and emergency care and referral.

22. Malaria, currently the country's most life-threatening disease, causes 30 per cent of all deaths in paediatric wards. UNICEF support focused primarily on making prompt and correct treatment accessible at the community level through village health workers. It also included the distribution of 178,000 impregnated bednets to all families with infants on Zanzibar and to

pilot areas in three mainland regions. Morbidity reductions of around 40 per cent were documented in 1991 in children under five years of age in a trial pilot area. Based on those results, expanded trials are proposed under the new programme.

23. Diarrhoeal diseases, still a major public health problem in the United Republic of Tanzania, are attacked simultaneously from the village level upwards and the national level downwards through the integration of control measures with water supply and sanitation interventions. The annual distribution of oral rehydration salts sachets has reached almost 8 million in rural areas and 500,000 in towns.

24. Acute respiratory infections (ARI), worst in the highland areas, are controlled as part of primary health care (PHC) and in UNICEF-supported, community-based programmes. Efforts focused on improved treatment and case management.

25. Support for water supply and sanitation is an integral part of community-based programmes. Special attention is given to districts where water-related diseases most seriously affect the nutritional status of children. Community involvement is an essential element of all water supply programmes. Environmental sanitation and education emphasize improved hygiene and sanitation practices. UNICEF has also provided basic supplies for improved ventilated latrines, which are built by household members themselves.

26. Support for early childhood development focused on the urgent need to foster low-cost community arrangements for the care of children of preschool ages. Social welfare and community development staff, working within the community-based programmes and their child monitoring systems, have been instrumental in helping villagers form over 1,150 child-care posts. Malnourished children are specifically targeted for service by these posts.

27. UNICEF assistance for basic education continued to focus on support by the educational system to community-based efforts. Activities in curriculum development and the training of at least two teachers from each of the country's 10,431 primary schools strengthened knowledge and skills for improving the chances of children for survival and development. A national task force was formed to look into the implications of the recommendations of the World Conference on Education for All. Because of its concern about the deteriorating educational system, UNICEF commissioned a review of its support in this sector. The review, held in September 1990, led to increased UNICEF commitments to national policy and strategy development and to renewed emphasis on strengthening local management of basic education.

28. In 1990, the President of the United Republic of Tanzania launched a comprehensive and integrated retraining exercise in health education, later known as the Health Education Initiative. This "third channel" education

initiative involved training at all levels and the distribution of thousands of copies of health education materials, including 200,000 copies of the Swahili version of Facts for Life, which is available in every village.

29. Reported cases of AIDS increased rapidly to 7,106 in March 1991. UNICEF has supported an extensive information and education effort and has also assisted in developing community-based care strategies for AIDS orphans, who number more than 48,000 in the Kagera region alone.

30. Programme communication was supported within the health, nutrition, water supply and sanitation, safe motherhood and MCH programmes. The approach, which includes the fruitful involvement of the mass media, was strengthened with the use of traditional media and animators to facilitate the increased involvement of women in communication. Mass communication efforts, including the use of information from the community-based CSD monitoring system, have been instrumental in maintaining high attendance rates on village health days.

31. UNICEF support to social statistics aimed at more reliable and local planning and the assessment of programmes so as to reduce the death rate of young children. Most of this support went to the Government Bureau of Statistics to build capacity for household surveys of social conditions and to publish a series of reports of socio-economic data.

32. The global goals for children in the 1990s were endorsed by the United Republic of Tanzania when President Ali Hassan Mwinyi participated in the World Summit for Children. A national summit of members of the National Assembly, which met at Dar es Salaam on 7 June 1991, and a summit on Zanzibar on 3 October 1991 with the House of Representatives, endorsed the global goals as an appropriate challenge for the country.

33. Data for monitoring progress towards the goals will be provided by national household survey programmes and improved administrative information systems. Funds provided by the World Bank and DANIDA are helping to strengthen planning and monitoring systems in health and education. UNICEF is supporting the nutrition surveillance programme. Through the project on the social dimensions of adjustment, whose lead agency in the country is the United Nations Development Programme (UNDP), the Swedish International Development Agency (SIDA) and Statistics Sweden will provide additional support for strengthening the Bureau of Statistics' household survey programme. With respect to some of the groups of children in especially difficult circumstances, more qualitative, periodic research will be needed. Support for this has been provided in the past by the Norwegian Agency for International Development (NORAD) and UNICEF.

Major Summit goals for the United Republic of Tanzania

			1990	2000
1.	IMR (per 1,000 live births)	Mainland (1985)	115	50
		Zanzibar (1985)	120	50
	U5MR (per 1,000 live births)	Mainland (1990)	191	70
		Zanzibar (1986)	202	70
2.	MMR (per 100,000 live births)	Mainland (1990)	200-400	100-200
		Zanzibar (1990)	300	150
3.	Malnutrition			
	Under-five malnutrition (%) (underweight) - moderate and severe	Mainland (1990)	50	24
		Zanzibar (1990)	51	24
4.	Water			
	Access to safe drinking water (%)	Mainland (1989)	48	100
		Zanzibar (1988)	42	100
5.	Sanitation			
	Access to sanitary means of excreta disposal (%)	Mainland (1987)	64	100
		Zanzibar (1989)	49	100
6.	Basic education			
	Enrolment ratio at primary level (%)	Mainland (1990)	78	100
		Zanzibar (1989)	62	100
	Grade one enrolment completing primary school (%)	Mainland (1989)	75	80
		Zanzibar (1988)	60	80
7.	Adult literacy rate (%)	Mainland (1989)	90	94
		Zanzibar (1987)	62	79

IMR = infant mortality rate.
U5MR = under-five mortality rate.
MMR = maternal mortality rate.

RECOMMENDED PROGRAMME COOPERATION, 1992-1996

Recommended general resources: $38,500,000
Supplementary funding: $29,851,000

Recommended programme cooperation a/

(In thousands of United States dollars)

	General resources	Supplementary funds b/	Total
Health	12 229	11 103	23 332
Water supply and sanitation	3 517	3 780	7 297
Nutrition	1 630	308	1 938
Household food security	1 630	309	1 939
Education	3 101	5 807	8 908
Community organization and development	3 563	1 883	5 446
Young child development	1 034	1 936	2 970
Women in development	1 415	510	1 925
Social mobilization and advocacy	3 588	1 800	5 388
Planning and social statistics	3 618	1 835	5 453
Programme support	3 175	580	3 755
Total	38 500	29 851	68 351

a/ The breakdown for estimated yearly expenditures is given in table 3.

b/ In addition, there are also funded supplementary funding projects shown in table 3.

34. The new country programme is based on a strategy and a framework within which the goals for children in the 1990s can be achieved. Community-based approaches, developed with support from UNICEF since 1984, lie at the heart of the country programme strategy. The strategy is based on the assumption that many of the resources needed to achieve the global goals are already present in the United Republic of Tanzania's communities. Those can be used more effectively provided people have improved knowledge and understanding of their problems and provided support from outside is available. While the strategy is community based, support from district and national levels is essential.

35. In the community-based strategy, nutrition is used as an entry point for communities' analysis of their problems and for progress in resolving some of those problems. Growth monitoring systems provide the operational basis for the day-to-day management of the process. It is much more than a nutrition strategy, however. The strategy is also an approach to social development that allows communities to address a wide range of critical problems in the area of health, education, women's situations and water supply and sanitation, using children's nutritional status as the entry point. Similarly, district and national staff use reports from the community system in making decisions about the allocation of resources.

36. In addition to existing public expenditures, about $2.50 per child per year is needed for the core elements of a community-based programme, of which approximately half is local expenditure. The communities' in-kind contributions, such as labour, time and food, are not included in this estimate, nor are the costs of the Government's existing staff infrastructure, which makes this programme approach feasible at a modest additional cost.

37. Direct support to district and community-based actions to improve the well-being of women and children will be provided in varying degrees in the new programme to each of the mainland's 20 regions and to Zanzibar. Support at the national level will concentrate on strategy and methodology development assuming coordination of national and international resources for the mainland and Zanzibar. The overall objective of UNICEF support is to improve capabilities at all levels to assess, analyse and to take action so as to reduce maternal and child mortality and malnutrition rates.

38. Twelve regions will receive substantial support for community-based actions in both rural and urban communities. In those 12 regions, the goals will be to reduce severe malnutrition to 2 per cent to reduce moderate malnutrition and maternal mortality by half and to improve the nutritional status of women. All communities will establish improved management systems for early childhood development and Education for All, management systems for integrated health and sanitation services and water supplies, and for improved access to credit, tools and markets for households with malnourished children.

39. Complementing programmes funded by NORAD and the World Bank, limited support will be provided in four regions for a community-based management training package and information system and for various national programmes such as Facts for Life, health education and immunization. Another four regions will be supported through assistance to the Tanzania Food and Nutrition Centre for establishing the community-based approach. The goals in those regions will be to reduce severe malnutrition to 3 per cent, moderate malnutrition and maternal mortality by 40 per cent and to improve the nutritional status of women.

40. UNICEF support will aim to strengthen analysis and management systems in communities and districts and at the national level. Crucial, particular determinants of the well-being of women and children will be addressed through support to improve the adequacy of food intake, child development and education, health, water supply and sanitation and income generation in poor households.

41. UNICEF support for community mobilization, participation and management will facilitate the capabilities of both parents and communities to identify and articulate their problems. It will also strengthen the capacity of decision makers and others to play a part in solving those problems. Intensive advocacy, communication and training should result in better assessment and analysis, in addition to resource mobilization and allocation.

42. District management systems are as essential to the success of community-based activities as communities' resources. District staff need improved management systems so that they can spend more time working with communities than planning for them. The role of UNICEF support will be specifically to facilitate intersectoral coordination; to develop more effective community and ward involvement in management, especially in health and education; and to promote the use of an integrated management information system.

43. UNICEF support for policy and strategy analysis, planning and monitoring will strengthen the United Republic of Tanzania's long-standing efforts to formulate national policies and implementation strategies benefiting women and children. Involving legislation, planning strategies, data collection and management systems that currently tend to overlook or underestimate gender concerns and the priority needs of children, it will strengthen policy and planning frameworks for the survival and development of women and children.

44. Support for coordination, management and community development will provide the guidance and support from the national level that is needed by districts, wards and communities in their efforts to improve the situation of women and children.

45. Improving the adequacy of food intake is key to reducing the high malnutrition rate in the United Republic of Tanzania. Limited access to food, particularly because of low feeding frequencies and the low energy density of food, are the most important immediate causes of this problem. More basic causes are the heavy workloads of women and their limited access to resources. Improved community capability and skills for the assessment and analysis of those causes are essential, in addition to food production, processing and utilization. Training will increase the awareness of village governments of their existing and potential resources and will be directed towards increasing their support to households lacking resources. Extension support will be strengthened with an integrated animation approach. In some areas, special attention will be needed to address shortages of fuelwood and environmental degradation.

46. In collaboration with the Food and Agriculture Organization of the United Nations (FAO), UNICEF will support advocacy, research and retraining in nutrition and food security at the national level in order to widen the present focus on food production and crop targets. Issues such as women's workloads, feeding frequency, dietary bulk, breast-feeding, vitamin A and iodated salt for iodine deficiency disorders will be addressed as part of a comprehensive strategy.

47. In the area of child development and education, UNICEF support will help to improve community management systems to ensure basic education for all. Special attention will be given to coordination with existing reporting and data collection systems. The ward education office will be developed as a major education resource centre. Essential inputs, especially books and teacher training, are major elements of other agencies' support for education, especially the World Bank, SIDA, DANIDA and NORAD.

48. UNICEF support to national education and child development programmes will encourage policy reviews, the measurement of curricula and child development and the monitoring of cognitive development. A reformulation of the national basic education policy, to be completed and made available in 1992, is expected to provide a better opportunity to review more comprehensively the quality of basic education, including early childhood development. Accordingly, the programme of cooperation will address issues related to improving the quality of education through effective joint annual reviews with the Government.

49. Health and water supply and sanitation strategies that promote community involvement and PHC will be strengthened by UNICEF support in the new programme. Village health committees have been successful, particularly in the context of integrated, community-based CSD programmes where growth monitoring is the key to the entire management information system, and where close links have been maintained between traditional and modern health services. UNICEF will continue to support community-based health workers, including traditional birth attendants and water attendants, with training

and/or retraining programmes and the provision of basic supplies. Pregnancy monitoring and operational referral systems will be new elements of support. Encouraging results of trials of community-managed actions to control malaria and ARI will be carefully reviewed and suitable systems put in place in increasing numbers of communities. Community-based strategies for the control of diarrhoeal diseases (CDD) and of human immunodeficiency virus (HIV)/AIDS will be pursued, informed by ethnographic and other studies.

50. Long-term sustainability will be promoted with support for the cost-effective management of immunization and other basic health services. Districts will be the focal points for the management of health and water supply and sanitation services, along the lines of the Bamako Initiative. Communities will receive support to increase their role in managing social services and in contributing, in appropriate ways, to the costs of those services.

51. Future development of the water supply, sanitation and hygiene education components of the programme will focus on the application of low-cost, appropriate technologies and approaches; the building of local capacity to plan, implement and manage water supply and sanitation projects; and, through advocacy at the national level, helping to formulate appropriate sector policies that will enhance the acceleration of coverage, especially to the poor. Additional support will be provided at national and subnational levels to better manage and consolidate the sector through capacity-building for effective monitoring.

52. National support will concentrate on helping to integrate health, water supply and sanitation programmes that are currently vertical. That integration will, in itself, improve support to community involvement and people's participation in health, water supply and sanitation development and will address some resource constraint issues. The long-standing support of UNICEF for major national initiatives such as the immunization programme will continue. Because of its crucial role in maintaining quality health services, continuing support for the provision of essential drugs will be especially important.

53. Income generation in poor households is crucial to the reduction of child and maternal mortality. Women's income sources are limited to labour-intensive, informal sector activities that provide low returns. Even so, credit is not easily available and many women struggle in isolation when they could be stronger by working together in groups with similar aims. UNICEF will support the organization and strengthening of community groups that can improve possibilities for income generation for households with malnourished children and for poor women. Access to credit, tools and markets will be facilitated.

Advocacy and external relations

54. Support for advocacy and external relations will build on earlier experience with forging alliances, institutional and national capacity-building, intensified media relations and the provision of information on CSD concerns. It will also include advocacy for the global goals for children in the 1990s and for the Convention on the Rights of the Child, as well as support for the initiatives of regional intergovernmental organizations. More emphasis will be given to involving non-governmental organizations, the number of which is increasing, although it is still relatively small. Opportunities for collaboration will be pursued. Increasing opportunities for fund-raising exist through local charitable organizations and they will be actively explored.

Evaluation

55. The entire programme approach incorporates the systematic use of information for planning and monitoring. The national system for monitoring the achievement of child development goals in the 1990s will provide national decision makers with regular progress reports. Experience with community-based monitoring systems for existing CSD programmes will provide the basis for the further development of those systems. Evaluations will be conducted of general aspects of the programme approach, further improvements in the community-based monitoring system, the effectiveness of animation training for community development workers, as well as of more specific issues such as the effectiveness of malaria control measures and operations and maintenance systems for water supplies. An evaluation of programme implementation is planned for early 1994, in advance of the mid-term review expected later that year. In addition, there will be specific evaluations of the programmes and projects funded through supplementary funding. Studies essential for the complete operation of the "triple A" nutrition strategy will be supported.

Inter-agency cooperation

56. UNICEF will strengthen its support for the National Coordinating Committee for Child Survival and Development. That support will aim to strengthen capabilities within communities, districts and at the national level and thus assist Tanzanians in achieving the ambitious goals for women and children to which they have committed themselves.

57. The new programme has taken into account the United Republic of Tanzania's existing and future support from other agencies in order to maximize the impact of UNICEF resources. Many bilateral and multilateral agencies provide support to the social sectors, especially at the national level. Because much less support is provided to communities and districts, most of UNICEF assistance is concentrated there, with proper linkages

established to the national-level support provided by other agencies. Overall coordination of support from external agencies to the country's women and children is managed through the Planning Commission and the National Coordinating Committee for Child Survival and Development.

58. The community-based programme approach has been reviewed favourably by other agencies, including the World Bank. It is increasingly used in regions and districts not covered by comprehensive UNICEF assistance. During the period 1992-1996, UNICEF expects to provide extensive support in 12 regions. However, with additional support expected from the World Bank, NORAD, SIDA, the German Agency for Technical Cooperation, the International Fund for Agricultural Development (IFAD) and the European Community, almost every district will have a community-based programme by the middle of the decade.

59. UNFPA and UNICEF, both of which are starting new programme cycles in 1992, have closely aligned their planned support for social statistics and safe motherhood at the national level. UNFPA expects to assist with family planning inputs in the regions and districts where UNICEF cooperates. Collaboration with FAO has ensured that UNICEF support for household food security will form an integral part of the country's new national food security strategy and programme. UNICEF works closely with WHO, especially in the areas of immunization, essential drugs, CDD and AIDS prevention. In the health sector, continuing collaboration with DANIDA is also anticipated.

TABLE 1. BASIC STATISTICS ON CHILDREN AND WOMEN

United Republic of Tanzania		(1990 and earlier years)	UNICEF country classification
Under-five mortality rate	170	(1990)	Very high U5MR
Infant mortality rate	102	(1990)	Very high IMR
GNP per capita	$ 120	(1990)	Low GNP
Total population	27.3 Million	(1990)	

KEY INDICATORS FOR CHILD SURVIVAL AND DEVELOPMENT		1970	1980	1985	1990
Births	(thousands)	699	931	1111	1387
Infant deaths (under 1)	(thousands)	93	112	123	141
Under-five deaths	(thousands)	156	188	206	236
Under-five mortality rate (per 1,000 live births)		223	202	185	170
Infant mortality rate (under 1) (per 1,000 live births)		133	120	111	102

		About 1980	Most recent
Underweight children (under 5) (% weight for age, 1980/1988)	Moderate & severe	..	48*
	Severe	..	6*
Babies with low birth weight (%, 1984)		13	14
% of primary school children reaching final grade (1980/1988)		..	71

NUTRITION INDICATORS		About 1980	Most recent
Mothers breast-feeding at 3/6/12 months (%, 1983)		../../..	100*/ 90*/ 70*
Prevalence of wasting (%)		..	..
Prevalence of stunting (%)		..	..
Daily per capita calorie supply (% of requirements, 1979-1981/1988)		98	93
Food production per capita index (Index 1979-1981=100, 1980/1990)		97	85
Household expenditure (% of total income, 1980-1985)	All food/cereals		64 / 32

HEALTH INDICATORS		About 1980	Most recent
ORT use rate (%, 1989)			37
Access to health services	Total	76	..
(% of population, 1980)	Urban/rural	99 /72	../..
Access to safe water	Total	49*	56
(% of population, 1980/1988)	Urban/rural	90*/41*	75/46
Access to adequate sanitation	Total	..	68
(% of population, 1985)	Urban/rural	.. /..	93/58
Births attended by trained personnel (%, 1988)		..	60
Maternal mortality rate (per 100,000 live births, 1986)		..	340

Immunization		1981	1985	1990
One-year-olds (%) immunized against:	Tuberculosis	78	93	..
	DPT	58	69	..
	Polio	49	65	..
	Measles	76	76	..
Pregnant women (%) immunized against	Tetanus	36	38	..

/...

TABLE 1 (continued)

United Republic of Tanzania

EDUCATION INDICATORS		About 1980	Most recent
Primary enrolment ratio (gross/net)	Total	93/ ..	66 / 50
(%, 1980/1987)	Male	100/ ..	67 / 50
	Female	86/ ..	66 / 51
Secondary enrolment ratio (gross/net)	Total	3/ ..	4 / ..
(%, 1980/1987)	Male	4/ ..	5 / ..
	Female	2/ ..	3 / ..
Adult literacy rate, 15 years & older	Total	33	91*
(%, 1970/1986)	Male/female	48/ 18	93*/ 88*
Radio/television sets			
(per 1,000 population, 1980/1988)		../ 0	20 / 1

DEMOGRAPHIC INDICATORS		1970	1980	1985	1990	2000**
Total population	(Million)	13.5	18.9	22.7	27.3	39.6
Population aged 0-15 years	(Million)	..	9.6	11.6	14.0	20.5
Population aged 0-4 years	(Thousands)	..	3801.5	4595.0	5580.6	7895.2
Urban population (% of total)		7	16	24	33	46
Life expectancy at birth	Total	45	50	52	54	58
(years)	Male	44	48	50	52	56
	Female	47	52	54	56	60
Total fertility rate		6.9	7.1	7.1	7.1	6.6
Crude birth rate (per 1,000 population)		51	51	51	50	47
Crude death rate (per 1,000 population)		20	16	15	13	11

		About 1980	Most recent
Contraceptive prevalence rate		1	8*
(%, 1977/1987)			
Population annual growth rate	Total	3.3	3.7
(%, 1965-1980/1980-1990)	Urban	8.7	10.6

ECONOMIC INDICATORS		About 1980	Most recent
GNP per capita annual growth rate		0.8	-0.7
(%, 1965-1980/1980-1990)			
Inflation rate (%, 1965-1980/1980-1989)		10	26
Population in absolute poverty	Urban/rural	../..	15*/25*
(%, 1982)			
Household income share	Top 20%/bottom 40%	50/16	.. /..
(%, 1969)			
Government expenditure	Health/education	6/13	6 / 8
(% of total expenditure, 1980/1985)	Defence	9	16
Household expenditure	Health/education		1 / 5
(% of total income, 1980-1985)			
Official development assistance:	US$ millions	..	918
(1980/1989)	As % of GNP	..	30
Debt service			
(% of goods & services exports, 1980/1989)		11	13

Definitions, sources and symbols are described in the section preceding these data sheets.

* UNICEF field office source.

** United Nations Population Division projections based on past and current trends.

TABLE 2. EXPENDITURE UNDER PREVIOUS COOPERATION PERIOD, 1987-1991

(In thousands of United States dollars)

COUNTRY: UNITED REPUBLIC OF TANZANIA
LATEST BOARD APPROVAL: 1986
GENERAL RESOURCES: $23,825,000

	Supplies and equipment (incl. freight)		Training grants		Project staff		Other cash		Totals		
	GR	FSF	GR	FSF	GR	FSF	GR	FSF	GR	FSF	Total
Health	5650	34756	763	455	330	1053	728	1156	7471	37420	44891
Water supply and sanitation	423	166	44	3	330	45	192	85	989	299	1288
Nutrition	1769	2615	987	396	216	772	1129	1365	4101	5148	9249
Education	691		630		51		654	5	2026	5	2031
Community organization and development	322	223	239	60	153		632	96	1346	379	1725
Women-centred programme	373	33	137		82		439		1031	33	1064
Advocacy	31		39		97		70		237		237
Emergency	41								41		41
Planning and project support	1658	297	106	39	3000	216	976	656	5740	1208	6948
Freight	726	1370							726	1370	2096
GRAND TOTAL	11684	39460	2945	953	4259	2086	4820	3363	23708	45862	69570

GR = General resources.
FSF = Funded supplementary funding.

/...

TABLE 3. PLANNED EXPENDITURE, 1992-1996

(In thousands of United States dollars)

Country: UNITED REPUBLIC OF TANZANIA Period covered: 1992-1996	Funding status	1992	1993	1994	1995	1996	Total
Health	GR	2337	2315	2531	2523	2523	12229
	FSF	10092	829	0			10921
	NSF	1331	1348	2722	2816	2886	11103
Water supply and sanitation	GR	1022	600	633	631	631	3517
	FSF	366	38				404
	NSF	808	747	805	758	662	3780
Nutrition	GR	304	320	329	338	339	1630
	FSF	723	300	219			1242
	NSF	33	60	85	73	57	308
Household food security	GR	304	320	329	338	339	1630
	FSF	5	3				8
	NSF	33	60	85	73	58	309
Education	GR	816	647	516	546	576	3101
	FSF	8	11				19
	NSF	1294	1128	1206	1131	1048	5807
Community organization and development	GR	616	785	736	720	706	3563
	FSF	478	338	65			881
	NSF	223	298	503	460	399	1883
Young child development	GR	272	216	172	182	192	1034
	FSF	3	3				6
	NSF	431	377	402	376	350	1936
Women-centred programme	GR	215	300	300	300	300	1415
	FSF	110	55				165
	NSF		100	135	165	110	510
Social mobilization and advocacy	GR	628	762	748	732	718	3588
	FSF	318	225	33			576
	NSF	223	298	469	425	385	1800
Planning and social statistics	GR	551	800	771	755	741	3618
	FSF	428	343	47			818
	NSF	223	298	483	440	391	1835

TABLE 3. PLANNED EXPENDITURE, 1992-1996 (continue)

(In thousands of United States dollars)

Country: UNITED REPUBLIC OF TANZANIA Period covered: 1992-1996	Funding status	1992	1993	1994	1995	1996	Total
Programme support	GR	635	635	635	635	635	3175
	NSF	100	120	120	120	120	580
TOTAL	GR	7700	7700	7700	7700	7700	38500 a/
	FSF	12531	2145	364			15040
	NSF	4699	4834	7015	6837	6466	29851
GRAND TOTAL		24930	14679	15079	14537	14166	83391

GR = General resources.
NSF = New supplementary funding.
FSF = Funded supplementary funding.
a/ This amount excludes $1,730,000 from general resources previously approved.

TABLE 4. STAFFING FROM BUDGET AND PROGRAMME FUNDS

COUNTRY: UNITED REPUBLIC OF TANZANIA	Number of posts	Amount (Thousands of United States dollars)
FINANCED FROM 1992-1993 APPROVED BUDGET:		
International Professional established posts	4	953
Local national Professional and General Service established posts	17	516
Operating costs		1162
Total	21	2631
FINANCED FROM PROGRAMME FUNDS: a/		
International Professional project posts		
General resources	9	2050
Supplementary funds	6	1300
Local national Professional and General Service project posts		
General resources	42	1188
Supplementary funds	21	550
Total	78	5088

a/ For information source, see the 1992 revised post authorization table, dated 23 July 1991.

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1992 session

FOR ACTION

COUNTRY PROGRAMME RECOMMENDATION*

The Congo

The Executive Director recommends that the Executive Board approve the country programme of the Congo for the period 1992 to 1996 in the amount of $5 million from general resources, subject to the availability of funds, and $3,227,000 in supplementary funds, subject to the availability of specific-purpose contributions.

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* In order to meet documentation deadlines, this document was prepared before aggregate financial data were finalized. Final adjustments, taking into account unspent balances of programme cooperation at the end of 1991, will be contained in the "Summary of 1992 recommendations for general resources and supplementary funding programmes" (E/ICEF/1992/P/L.2 and Add.1).

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THE SITUATION OF CHILDREN AND WOMEN

1. The Congo is a potentially rich developing country. Its environment, its subsoil, and especially, its women and its men provide it with all the assets required for self-directed and sustainable development. The Congo is a "middle-income" country, outstripping many neighbours with a gross national product (GNP) per capita of $930. Despite these resources, no positive correlation exists between the indicators of the level of well-being of children and women and the country's level of wealth.

2. The pressure exerted by international banking institutions for the repayment of the Congo's external debt has compelled the Government to adopt severe economic adjustment measures. In order to reduce the budget deficit, it has sharply cut public expenditures. The resulting decrease in State revenues, and management difficulties, have affected the level of basic services and have led to the gradual impoverishment of Congolese society. Rural migration and the rise of the urban informal sector have accompanied this impoverishment, the impact of which has been intensified by unrealistic choices in the social sectors; specialized health units have been built at the expense of basic health care facilities, and the major portion of education budgets has been devoted to the university sector at the expense of basic education.

3. Despite stated espousal of primary health care (PHC), the Congo is not yet able to offer a really efficient health care system. While physical access to health care is satisfactory (83 per cent), and while the doctor-patient ratio is among the best in Africa (one doctor per 5,000 inhabitants), the accessibility of care is purely theoretical. Indeed, most health facilities do not have the equipment and drugs essential to satisfying the basic health needs of the population.

4. The under-five mortality rate is 110 per 1,000 live births, while the maternal mortality rate (MMR) is estimated at 900 per 100,000 live births. As a result of the expanded programme on immunization (EPI), the incidence of such diseases as whooping cough or measles has declined substantially; poliomyelitis and neonatal tetanus are even being eradicated. Currently, the principal child public health problems are malaria, diarrhoeal diseases, acute respiratory infections, acquired immune deficiency syndrome (AIDS) and tuberculosis.

5. Venereal diseases constitute nearly 50 per cent of the causes of infertility. Women represent 47 per cent of reported AIDS cases in the 20 to 50 years age group. The sentinel-site monitoring system has shown that in 1990, from 5 to 6 per cent of pregnant women in urban areas tested positive for the human immunodeficiency virus (HIV).

6. The safe drinking water supply, a crucial element in preventing disease and promoting health, is still insufficient. In 1987, barely 7 per cent of the rural and 42 per cent of the urban population had safe drinking water.

The sewage disposal system is far from able to satisfy the needs of the rapidly expanding urban population. A major investment effort is required in this sphere.

7. A study of the nutritional status of children, conducted in 1987, shows that, on average, 13 per cent of newborns have low birth weight. Four per cent of preschool-age children are thin, 17 per cent are underweight and more than 20 per cent show retarded growth. The highest prevalence of malnutrition is in the 3 to 24 months age group. The immediate causes of this are the premature feeding of weaning gruel and the family diet, the insufficient protein-caloric density of weaning food, and the toll taken by infections. On the other hand, breast-feeding continues at least up to 12 months of age.

8. Basic education is in a paradoxical situation: despite a primary enrolment rate of 100 per cent, the illiteracy rate among persons aged 15 years and older is 43 per cent; 56 per cent of illiterates are women. The average repetition rate at the primary level is 37 per cent. For every 1,000 pupils enrolled in the first year of the primary level, 750 will reach the sixth year, after an average of 11 years of schooling. Of these 750 pupils, only 562 will complete the primary level. The percentage of girls in school falls from 47.5 per cent at the primary level to 44 per cent in the first part of the secondary level, to 26 per cent in the second part of the secondary level, and to 17 per cent at the post-secondary level. Lastly, State expenditures per capita were 30 times higher at the post-secondary level than at the primary level. Preschool education is underdeveloped. Only 3 per cent of children in the relevant age group are enrolled; the curriculum is inappropriate and is taught by insufficiently qualified teachers.

9. The Congolese educational system is constrained by the lack of a clear policy backed by a level of resource allocation which is in keeping with the stated priorities. The consequences of this are teachers who are underqualified and in short supply, and classrooms which are dilapidated and few in number, resulting in overcrowding; likewise, there is a widespread shortage of teaching materials.

10. While the legislation in force provides for equality between men and women, the many roles which women play in society constitute obstacles to their full development. Women are mothers, producers, wives, teachers, students and workers, all at the same time. They are overburdened with domestic chores. Women represent 64 per cent of the workforce in agriculture and 69 per cent in retail trade. Each woman has an average of five children. Girls have access to schooling, but their retention rate is low as compared with that of boys. The political changes under way raise hopes for a substantial improvement in the status of women.

11. More than 60 per cent of the population lives in urban areas, and the four major cities (Brazzaville, Pointe Noire, Lonbomo and Nkayi) account for 52 per cent of the total population. This situation results from rural migration, which also leads to the ageing of the rural population and casts

doubt over the prospects for the development of the agricultural sector. This strong tendency towards urbanization is accompanied by the phenomenon of street children, which has been growing recently in the context of a socio-economic crisis, particularly in urban areas. The main categories which have been identified are street children, working children, child offenders under supervision, child drug users and girl prostitutes.

PROGRAMME COOPERATION, 1988-1991

Objectives and strategies

12. The 1988-1991 programme had the following aims: (a) to increase the immunization cover to 80 per cent and improving maternal and child health (MCH) surveillance; (b) to increase the number of beneficiaries, the quality and the accessibility of essential primary health care (PHC) services; (c) to reduce the frequency of waterborne diseases and the burden placed on women as carriers of water, by extending the drinking water supply; (d) to develop additional innovative activities and increase support for child survival and development (CSD) through the project on women, production, and integration into development.

Health

13. In May 1990, the Congo achieved the universal child immunization (UCI) target for Africa, by raising immunization coverage for each of the vaccines to 75 per cent. This achievement was made possible by the systematic incorporation of immunization activities into 160 health centres. These centres provided access for approximately 90 per cent of the population. With immunization costs of $22 per child ($2.40 for each correctly administered dose), the expanded programme on immunization (EPI) is nevertheless encountering a number of problems. Its ability to sustain those gains in the short term thus depends to a large extent on the continued provision of external assistance for all costs, except wages. Furthermore, the spread of measles epidemics, particularly in urban areas, necessitates the development of new immunization strategies. Finally, if poliomyelitis and neonatal tetanus are to be eradicated, an effective monitoring system is required.

14. The programme to combat diarrhoeal diseases has reached its accessibility targets. At present, 160 oral rehydration therapy (ORT) units are providing access for approximately 70 per cent of the population. There is still scope for improvement in ORT use, however, since only 25 per cent of the mothers of diarrhoea-affected children in urban areas are using this therapy. Forty-one per cent of diarrhoea cases are attended to at a health facility and 43 per cent of the children treated for diarrhoea are put on ORT (oral rehydration salts (ORS) or sugar and salt solutions). Among the children treated at home in urban areas, 16 per cent are on ORT (ORS or sugar and salt solutions). The constraints encountered include stock shortages in the ORT units, inadequate supervision of diarrhoea cases in the health centres and lack of measures to advise mothers on how to deal with diarrhoea. These

problems can all be solved through stricter management, more effective training and supervision and more dynamic social mobilization activities and by incorporating ORT in the integrated health centres operating on Bamako Initiative principles. Nevertheless, the continued viability of the project is affected by its heavy financial dependence on external aid for the majority of its costs, except those of health workers' wages.

15. The national malaria control policy, supported by UNICEF, is based on the early presumptive treatment of attacks of fever in children under five and pregnant women and on chemoprophylaxis with pregnant women. At present, 160 health centres are following the national policy, ensuring access for 70 per cent of the population. The rate of use is still below 25 per cent, however, because of the decision to target only children under five. In fact, there is very heavy demand from the adult population for a medicine which the State is hardly distributing any more to outlying centres. It seems essential to implement the national anti-malaria policy through health centres revitalized by the implementation of the Bamako Initiative. In addition, this national policy should be extended to prevention-related aspects, in particular, vector control and environmental sanitation.

16. The UNICEF contribution to the national AIDS programme formed part of the general campaign to reduce infant mortality. The activities programmed by UNICEF covered public information and education exercises, the training of paramedical staff and social instructors and counselling of HIV-positive women. The implementation rate has been satisfactory for information, education and communication (IEC) activities and for training exercises. The counselling activities have not developed in the manner envisaged, despite a study carried out by the Congo of the necessary conditions for the establishment of counselling centres. One constraint was the insufficiently decentralized management of the national AIDS programme, despite such praiseworthy initiatives as the creation of regional committees. Likewise, extensive efforts have been made to produce audio-visual materials, but there has been little evaluation of their impact. In addition, the IEC activities would benefit by being more specifically targeted at high-risk groups, for example, through measures to inform and mobilize school pupils and students on means of preventing AIDS and sexually transmitted diseases in general. An early detection policy particularly where pregnant women are concerned, is essential to the implementation of a care programme.

17. Congo's decision to follow the Bamako Initiative as a strategy for strengthening its health districts has necessitated a reorientation of the cooperation programme in the health sector. On a UNICEF initiative, a national workshop was held in July 1990 to study the means of implementing the Initiative. The recommendations arising from the workshop were used to draw up a plan of action for national health development for the period 1992-1996. Since then, all the multilateral and bilateral agencies have focused their health cooperation on this plan of action. The task of implementing the plan of action has been entrusted to a coordination group comprising representatives of the Ministry of Public Health and of the different multilateral and bilateral agencies.

18. The nutrition education project was taken over by UNICEF after the departure of the Cooperative of American Relief Everywhere (CARE) International in 1988. Funded from general resources until 1990, it has received funding from the French Fund for Aid and Cooperation (FAC) since 1991. A joint UNICEF/SAC assessment carried out in November 1990 led to the reformulation of the project. Under its new name (PAAN, or Project to Support Nutrition Activities), it is aimed at drawing up a nutrition policy for the benefit of preschool children, developing the necessary methods and tools for the implementation of this policy and implementing the various aspects of the policy in two areas, one urban fringe and the other rural. The project is planned to run until the end of 1992.

Water and sanitation

19. The execution rate of the project activities, which could have been higher, was hindered on the one hand by the lack of resources and on the other by a shortage of national expertise, particularly in the management of wells.

Women, production and integration

20. Throughout the entire cycle this project has received no additional funding. Its launching was made possible by general resource funding and it benefited from the increased limits in effect since 1989. As a result, the fulfilment level has fallen well short of the initial objectives.

The lessons of experience

21. Among the major lessons to be drawn from the execution of the programme is the need for greater integration of operational support activities (training, monitoring) in order to optimize costs, while permitting greater complementarity and coordinated action. The excessively vertical and restrictive nature of some health projects (to combat malaria, for example) causes them to lag behind the urgent restructuring of the health sector. Hence it is imperative to rethink disease control programmes within the overall context of the health system's rationalization and redeployment towards the periphery. To accomplish this, the national authorities must affirm their will to coordinate and integrate health system components with the activities of various cooperating groups.

22. Although the Government has taken appropriate CSD measures such as ratification of the Convention on the Rights of the Child, the resources allocated to the various implementing ministries are not always adequate to the level of commitment. The funds allocated to the health sector have been invested mainly in rehabilitation of large hospitals and in staff costs, rather than in optimizing the country's public health system operations. Advocacy should be continued at all levels for the establishment of essential mechanisms for decentralized monitoring of health care management. Furthermore, in terms of financing strategy, the difficulty in obtaining supplementary resources is of particular concern.

23. Evaluations and studies conducted during the programme implementation phase have not only helped to measure the successes, but also to identify constraints, with a view to reorienting strategies and improving the analysis of the situation. In future, special emphasis should be placed on limitations such as insufficient regional and local planning and execution capability, excessively centralized administration, inadequacy of coordination both within and between sectors, and inadequate follow-up and evaluation of execution and programming.

24. Nevertheless, some positive aspects were noted, such as the consolidation of health infrastructure (material and technical) which has made it possible to move ahead with the PHC activities, the possibilities offered by grass-roots organizations, rural women's groups in particular, in fostering community participation, the positive attitude of the media and artists and intellectuals towards social mobilization, and the effectiveness of the sentinel sites methodology, key elements in monitoring and evaluation.

RECOMMENDED PROGRAMME COOPERATION, 1992-1996

Recommended general resources: $5,000,000
Supplementary funds: $3,227,000

Recommended programme cooperation a/

(In thousands of United States dollars)

	General resources	Supplementary funds b/	Total
Health	3 129	1 803	4 932
Basic education	482	600	1 082
Advocacy	64	186	250
Social statistics	125	638	763
Programme support	1 200	-	1 200
Total	5 000	3 227	8 227

a/ The breakdown for estimated yearly expenditures is given in table 3.

b/ In addition, there are also funded supplementary funding projects shown in table 3.

Country programme goals and objectives

25. The objectives were determined through a synthesis of national priorities and world-wide strategies and objectives for children and development for the 1990s. Their aim is to improve conditions for child survival and physical and intellectual development while providing protection to mothers. To achieve these objectives, during 1992-1996 the country will emphasize activities leading to: (a) a reduction in infant mortality from 69 to 40 per 1,000 live births; (b) a reduction in the MMR from 900 to 630 per 100,000 live births; (c) a reduction in the incidence of underweight preschool children from 17 per cent to 12 per cent; (d) a reduction in the number of low birth weight infants to less than 10 per cent; (e) a reduction in the school drop-out rate, especially among girls, through improvement in the quality and effectiveness of basic education, making it compatible with the requirements of education for life; and (f) an improvement in information networks and data collection.

Strategies

26. The proposed overall strategy derives from the Congo's social policy guidelines, particularly the Economic and Social Plan of Action (1990-1994), and the UNICEF medium-term plan. It advocates consideration of the social dimension of development in all short- and medium-term national plans, in application of post-Summit strategies to achieve the objectives for the 1990s and to ensure implementation of the Convention on the Rights of the Child.

27. The strategy is based on development and strengthening of sectoral effectiveness, and on local community participation supported by administrative decentralization favouring promotion and utilization of basic services and appropriate, effective and widely available techniques. In this context, strengthening of national institutional and operational capacity, a guarantee of the long-term credibility of an activity, will be a priority.

28. Programmes which are nation wide in scope, for example those dealing with health and basic education, will emphasize micro-planning and management. As a whole, the country programme represents a multisectoral unit for meeting children's overall needs. One of its components is development of the skills required for each project, in order to overcome the major differences encountered too frequently by sectoral departments responsible for providing services. In addition to health and basic education, the programme includes various activities designed to improve the information base on children nationally, regionally and peripherally, in particular the consolidation of a national statistical data base, the establishment of a monitoring system, and acquisition of effective management tools at the district level with a view to improving programme planning and execution.

Health

29. The strategy for this programme is based on two complementary and synergetic principles of action. An integrated approach was selected which is based operationally on PHC and promotes the Bamako Initiative strategy, which alone is deemed capable of delivering the entire range of basic health care services - prevention, cure and promotion - in a drive for community participation in cost recovery and resource management. UNICEF participation in strengthening the health districts will lead to an improvement in national capacity, thus guaranteeing medium-term and long-term sustainability of the activities undertaken. Likewise, maintenance and strengthening of the achievements of EPI and ORT will be taken into account in the next programme.

30. The project to strengthen the health districts aims at providing 40 per cent of the population of the Kouilou, Brazzaville, Lekoumou and Plateaux regions with a high-quality primary health care system delivering essential MCH, curative and promotional services. This project is part of a national government effort to provide 70 per cent of the total population with basic health care services by 1996, through the combined assistance of all donors. The approaches used in this project include effective decentralization of the health system according to the district model developed by the World Health Organization (WHO), integration of essential care into outlying health centres, reduction of costs to the minimum through regular supply, rational utilization and management of essential drugs and supplies, and finally, an effort to make the people take responsibility for their own health, through community financing of local non-salary recurring costs, direct resource management and community solidarity with the most disadvantaged. Upon completion of the cooperation programme, this project will have established 74 integrated health care centres.

31. The EPI project objective is to achieve and maintain an 85 per cent level of immunization coverage for 1-year-olds and a 90 per cent level of anti-tetanus immunization coverage for women of childbearing age. Thus, this project will make a direct contribution to the eradication of poliomyelitis and neonatal tetanus. The 160 fixed vaccination centres will be maintained in urban fringe areas and remote rural areas, and established activities will be complemented by advanced mobile strategies. UNICEF financial support will decrease progressively as the Bamako Initiative is implemented.

32. The ORT project aims for a 30 per cent reduction in the diarrhoea-related mortality rate in children under five. UNICEF support will strengthen ORT utilization through administration of ORS in oral rehydration units and the use of salt-sugar solution as a primary home treatment. As in the case of EPI, UNICEF financial support will diminish progressively as the Bamako Initiative is implemented.

Basic education

33. Under this programme, UNICEF will assist the Congolese Government, in collaboration with other partners, in identifying and implementing a re-modelled basic education policy. This will encourage decentralization and the strengthening of national capacity in educational planning and management, promote the extension and improvement of preschool education and help raise the quality of primary education. In order to achieve these goals, two projects will be implemented: a national capacity-strengthening project in educational planning and a project to develop a new teaching approach.

34. The first project is aimed at better management of the data essential for defining and assessing basic education policies. The project's activities will be based on a thorough preliminary analysis of the constraints on the current system and will include training and refresher courses for central planning staff in the country's 10 regions. This project will supplement the second project, in that the planning skills thus created can be directly used to identify and test different teaching approaches. The second project seeks to develop a teaching model, based on adapted primary and preschool programmes, which will promote the acquisition of functional knowledge by children and reduce dropout. This model should also provide a solution to the problem of decentralizing educational management, through the more active participation of parents' associations. The project will give particular attention to the education of girls, in order to reduce the differences observed between the sexes. It will have two stages: first, the selection and development of a teaching approach, then the testing of that approach in a regional education office. The suitability of the approach selected will be measured in terms of the knowledge and skills acquired, the reduced numbers of pupils repeating classes and the diminished disparity between boys and girls.

Advocacy

35. The advocacy programme aims at promoting the operational and institutional changes necessary to improve the situation of children and women in the Congo. Two programmes will be developed. The first will advocate the implementation of a national programme of action for children. It aims at mobilizing the necessary resources for the implementation of this programme, particularly with regard to the implementation of the Convention on the Rights of the Child. The project approach will be through training and information measures aimed at previously identified strategic targets. These strategic targets will be selected at different levels of interaction in Congolese society. The second project will consist of active advocacy measures to promote recognition of the activities and multiple roles of women in society and to ensure greater autonomy and accountability of Congolese women. The project will undertake primarily to identify socio-cultural and institutional barriers and will then carry out training and information measures aimed at strategic targets, comprising both those who are responsible for creating the barriers and those who are also capable of effecting change.

Monitoring and evaluation

36. This programme comprises two projects, the first of which aims at developing a planning and surveillance system for children in order to produce an annually updated analysis of their situation at the national level and in each region. This system will be decentralized in order to ensure the participation of districts and regions in the process of data compilation and analysis. All the main development sectors will be involved in the discussion exercise. Local authorities, universities, research institutes and non-governmental organizations (NGOs) will be both partners and beneficiaries of the system that is set up. The second project will undertake to strengthen national and local capacities to monitor the situation of children and women. UNICEF will support the establisment of data compilation and analysis units designed to give a fuller picture of the situation.

Programme support

37. UNICEF will maintain an office in the Congo with the technical and administration staff necessary to ensure efficient management of its cooperation with the Government. The office operating costs will be borne by UNICEF, except for those expenses arising from the logistic and technical maintenance of certain programmes and projects, which will be charged to the programme budget.

Cooperation with the other agencies

38. UNICEF will continue to maintain and to strengthen its working ties with the other institutions in order to attain the national goals set for the 1990s. In particular, the PHC strengthening measures require close cooperation with the United Nations Population Fund (UNFPA), the German Technical Cooperation Agency, the European Development Fund, the World Health Organization (WHO) and FAC. FAC, UNFPA and the World Bank will be the main partners for the educational programme. Regular meetings will be held with the other donors and joint missions will be organized to ensure the integration and complementarity of the activities in progress.

TABLE 1. BASIC STATISTICS ON CHILDREN AND WOMEN

Congo	(1990 and earlier years)		UNICEF country classification
Under-five mortality rate	110	(1990)	High U5MR
Infant mortality rate	69	(1990)	High IMR
GNP per capita	$ 1010	(1990)	Lower-middle GNP
Total population	2271.0 Thousands	(1990)	

KEY INDICATORS FOR CHILD SURVIVAL AND DEVELOPMENT		1970	1980	1985	1990
Births	(thousands)	55	75	87	105
Infant deaths (under 1)	(thousands)	5	6	7	7
Under-five deaths	(thousands)	9	10	11	12
Under-five mortality rate (per 1,000 live births)		159	132	122	110
Infant mortality rate (under 1) (per 1,000 live births)		100	83	77	69

		About 1980	Most recent
Underweight children (under 5) (% weight for age, 1980/1987)	Moderate & severe	..	24
	Severe	..	..
Babies with low birth weight (%, 1979/1987)		15	16*
% of primary school children reaching final grade (1980/1988)		74	71

NUTRITION INDICATORS		About 1980	Most recent
Mothers breast-feeding at 3/6/12 months (%, 1980/1987)		97*/ 97*/ 85*	100*/ 98*/ 90*
Prevalence of wasting (%, 1980/1987)		..	13
Prevalence of stunting (%, 1980/1987)		..	33
Daily per capita calorie supply (% of requirements, 1979-1981/1988)		110	113
Food production per capita index (Index 1979-1981=100, 1980/1990)		100	92
Household expenditure (% of total income, 1980-1985)	All food/cereals		42/ 19

HEALTH INDICATORS		About 1980	Most recent
ORT use rate (%, 1989)			13
Access to health services	Total	..	83
(% of population, 1980/1985)	Urban/rural	../..	97/ 70
Access to safe water	Total	20*	38
(% of population, 1980/1988)	Urban/rural	40*/ 8*	92/ 2
Access to adequate sanitation	Total	..	..
(% of population, 1980/1987)	Urban/rural	../..	../ ..
Births attended by trained personnel (%, 1980/1987)		..	..
Maternal mortality rate (per 100,000 live births, 1971/1986)		1000	900*

Immunization		1981	1985	1990
One-year-olds (%) immunized against:	Tuberculosis	92	89	90
	DPT	42	54	79
	Polio	42	..	79
	Measles	49	67	75
Pregnant women (%) immunized against	Tetanus	..	..	60

/...

TABLE 1 (continued)

Congo

EDUCATION INDICATORS		About 1980	Most recent
Primary enrolment ratio (gross/net) (%, 1980/1988)	Total	../ ..	../ ..
	Male	../ ..	../ ..
	Female	../ ..	../ ..
Secondary enrolment ratio (gross/net) (%, 1980/1988)	Total	../ ..	../ ..
	Male	../ ..	../ ..
	Female	../ ..	../ ..
Adult literacy rate, 15 years & older (%, 1970/1990)	Total	35	57
	Male/female	50/ 19	70/ 44
Radio/television sets (per 1,000 population, 1980/1988)		65/2	122/3

DEMOGRAPHIC INDICATORS		1970	1980	1985	1990	2000**
Total population	(Thousands)	1263.0	1669.0	1939.0	2271.0	3167.0
Population aged 0-15 years	(Thousands)	..	692.9	927.1	1097.1	1557.6
Population aged 0-4 years	(Thousands)	..	266.6	359.9	427.3	599.3
Urban population (% of total)		33	36	38	40	47
Life expectancy at birth (years)	Total	46	50	52	54	58
	Male	43	47	49	51	55
	Female	48	52	54	56	60
Total fertility rate		6.2	6.3	6.3	6.3	6.1
Crude birth rate (per 1,000 population)		46	46	46	46	45
Crude death rate (per 1,000 population)		20	17	15	14	11

		About 1980	Most recent
Contraceptive prevalence rate (%, 1976/1987)		..	..
Population annual growth rate (%, 1965-1980/1980-1990)	Total	2.7	3.1
	Urban	3.5	4.3

ECONOMIC INDICATORS		About 1980	Most recent
GNP per capita annual growth rate (%, 1965-1980/1980-1990)		2.7	-0.2
Inflation rate (%, 1965-1980/1980-1989)		7	0
Population in absolute poverty (%, 1977/1988)	Urban/rural	../..	../ ..
Household income share (%, 1977/1988)	Top 20%/bottom 40%	../ ..	../ ..
Government expenditure (% of total expenditure, 1980/1989)	Health/education	../ ..	../ ..
	Defence	..	..
Household expenditure (% of total income, 1980-1985)	Health/education		22/ 2
Official development assistance: (1980/1989)	US$ millions	71	91
	As % of GNP	5	4
Debt service (% of goods & services exports, 1980/1989)		9	23

Definitions, sources and symbols are described in the section preceding these data sheets.

* UNICEF field office source.

** United Nations Population Division projections based on past and current trends.

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TABLE 2. EXPENDITURE UNDER PREVIOUS COOPERATION PERIOD, 1988-1991

(In thousands of United States dollars)

COUNTRY: CONGO
LATEST BOARD APPROVAL: 1988
GENERAL RESOURCES: $2,225,000

	Supplies and equipment (incl. freight)		Training grants		Project staff		Other cash		Totals		
	GR	FSF	GR	FSF	GR	FSF	GR	FSF	GR	FSF	Total
Health	752	411	238	158	10		553	324	1553	893	2446
Water supply and sanitation							4		4		4
Nutrition			25				174		199		199
Community organization and development	84	15	18		8		100	61	210	76	286
Women-centred programme							9		9		9
Planning and project support	50				702		258		1010		1010
Freight	22	41							22	41	63
GRAND TOTAL	908	467	281	158	720		1098	385	3007 a/	1010	4017

GR = General resources.
FSF = Funded supplementary funding.
a/ Including allocations to fund unfunded supplementary funding and allocations from global funds.

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TABLE 3. PLANNED EXPENDITURE, 1992-1996

(In thousands of United States dollars)

Country: CONGO Period covered: 1992-1996	Funding status	1992	1993	1994	1995	1996	Total
Health	GR	624	625	625	627	628	3129
	FSF	413					413
	NSF	366	328	350	417	342	1803
Education	GR	101	93	97	95	96	482
	NSF	350	63	63	62	62	600
Social mobilization and advocacy	GR	15	20	13	11	5	64
	NSF	51	33	37	35	30	186
Planning and social statistics	GR	25	25	25	25	25	125
	NSF	178	162	110	103	85	638
Programme support	GR	235	237	240	242	246	1200
TOTAL	GR	1000	1000	1000	1000	1000	5000
	FSF	413					413
	NSF	945	586	560	617	519	3227
GRAND TOTAL		2358	1586	1560	1617	1519	8640

GR = General resources.
NSF = New supplementary funding.

TABLE 4. STAFFING FROM BUDGET AND PROGRAMME FUNDS

COUNTRY: CONGO	Number of posts	Amount (Thousands of United States dollars)
FINANCED FROM 1992-1993 APPROVED BUDGET:		
International Professional established posts	3	718
Local national Professional and General Service established posts	9	735
Operating costs		621
Total	12	2074
FINANCED FROM PROGRAMME FUNDS: a/		
International Professional project posts		
General resources	1	211
Supplementary funds		
Local national Professional and General Service project posts		
General resources	5	300
Supplementary funds		
Total	6	511

a/ For information source, see the 1992 revised post authorization table, dated 23 July 1991.

Annex

LIST OF STUDIES AND ASSESSMENTS

Studies

1988: Updated analysis of the situation.

Background study for the project on water and sanitation.

Background study for the project on women, production and integration into development.

Pilot study on mortality among young people.

1989: Study on missed opportunities for immunization.

Study for the implementation of the Bamako Initiative in pilot districts.

Study of the *in vivo* effectiveness of certain insecticides designed to impregnate mosquito netting.

Study of neonatal tetanus mortality.

1990: Analysis of the situation of children and women.

Knowledge, attitudes and practices of mothers with regard to child diarrhoea.

Study of the chemoresistance of *P. falciparum* to chloroquin.

1991: Extent of the nutritional impact of the economic crisis in the urban context (Brazzaville).

Study to measure the effectiveness of a labour curve.

Assessments

1988: Assessment of immunization coverage.

Assessment of activities and infrastructures related to maternal and child health.

1989: Assessment of immunization effectiveness.

Assessment of immunization coverage in Pointe Noire.

1990: Assessment of national immunization coverage.

Administrative assessment of the nutritional education project.

1991: International EPI survey.

Technical review of the nutrition education project.